The questionnaires for parents

Do you approve of the participation of your child in this research (Participation in this research means filling out this questionnaire only) Yes/No?

Child's age _____ (Number between 5-18)

Child's Sex: M/F

Refers to a child with Covid 19 infection history:

When did your child have Covid 19 infection? (Month/Year)

During the Covid 19 infection, did your child have any symptoms? Yes/No

During the Covid 19 infection, was your child admitted to the hospital? Yes/No

If the answer is yes, was your child on respiratory support or admitted to PICU? Yes/No

To Covid 19 recovered patients only:

Does your child feel he fully recovered? Yes/No

Do you feel your child fully recovered? Yes/No

Below is a list of symptoms.

Please mark if your child has one or more of the following symptoms, more than he/she had before the Covid 19 infection? Or more than he/she had before the Covid 19 outbreak in Israel?

[all with yes/no options]

- Change in the sense of smell
- Change in the sense of taste
- Headache
- Shortness of breath
- Muscle pains
- Cough
- Rash
- Nausea
- Weakness
- Dizziness
- Joints aches
- Abdominal Pain

- Chest Pain
- Palpitations/Heart racing
- Vision disturbance
- Hearing disturbance
- The child has none of the above

In Addition, please mark if your child has one or more of the following symptoms than he/she had before the Covid 19 infection? Or more than he/she had before the Covid 19 outbreak in Israel?

[all with yes/no options]

- Fatigue
- Sleeping disturbances
- Anxiety or excessive worrying?
- Memory deterioration
- Confusion
- Weight loss or weight gain of more than 3 Kg in the last year
- Attention and/or concentration difficulties in school or kindergarten
- The child has none of the above symptoms

In general, how is your child's health in comparison to the condition before the Covid 19 infection or prior to the Covid 19 outbreak in Israel ?: Same/Better/Worse

Is your child on any chronic medications? Yes/No

If yes, Is the child getting chronic medications for one or more of the following conditions?

- Diabetes mellitus
- Asthma or chronic lung condition
- Chronic inflammatory or autoimmune condition
- Oncologic disorder
- Anxiety or depression
- None of the above

Does your child have or have an oncologic disorder? Yes/No

For 15 years of age or older only: is your child smoking? Yes/No

Was your child born in Israel? Yes/No

Weight: _____ Height: _____

We appreciate your cooperation!

We want to emphasize that this questionnaire is for research purposes only. The answers to the questionnaire are not observed or transferred to medical personnel and are not a replacement for seeking medical advice. In case of symptoms that require medical attention, please see your treating doctor.

We wish you good and full health!